Posttraumatic Stress Disorder (PTSD) Clinical Guidelines
Developed in collaboration with Beacon Health Options and the mental health centers associated with FBHP
DSM 5 code 309.81 and ICD-10 code F43.10

Diagnostic Considerations:
1. Establish diagnostic accuracy. Carefully review the DSM 5 criteria for PTSD. Key aspects of a PTSD diagnosis include:
   - Exposure to actual or threatened death, serious injury or sexual violence in one or more of the following ways:
     - Directly experiencing the traumatic event or events
     - Witnessing the event, as it occurred to others
     - Learning that the traumatic event occurred to a close family member or close friend
     - Experiencing repeated or extreme exposure to aversive details of the traumatic event
   - Exposure to a traumatic event alone is not sufficient for a diagnosis of PTSD.
   - Symptoms must persist for more than one month following the event.
   - Symptoms must cause significant impairment in functioning and include one or more intrusion symptoms:
     - Recurrent distressing memories
     - Recurrent distressing dreams
     - Dissociative reactions (e.g., flashbacks)
     - Intense or prolonged psychological distress when exposed to internal or external cues that symbolize or resemble an aspect of the trauma
     - Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the trauma.
   - Persistent avoidance of stimuli associated with the trauma.
   - Negative alterations in cognitions or mood associated with the trauma.
   - Specific criteria must be used for children who are 6 years and younger.

2. Consider differential diagnoses including Adjustment Disorder, Mood Disorders, Anxiety Disorders including specific phobias, and Obsessive-Compulsive Disorder. Also consider the diagnosis of personality disorders, dissociative disorders and conversion disorder. Rule out Acute Stress Disorder (ASD) when symptoms resolve within 4 weeks. Consider organic brain disorder, traumatic brain injury or a substance-induced disorder as a cause of flashback symptoms. Be aware of cultural norms to avoid treating common behaviors within a particular group as PTSD symptoms, e.g. limited expression of emotion may be categorized as an avoidance symptom, but is socially normative within certain cultures. PTSD is more common in females than in males and symptoms. Likewise, women may have symptoms for a longer duration than males on average.

3. Clinical assessment can include symptom checklists (PTSD checklist, Davidson Trauma Scale) or structured diagnostic interviews (Clinician Administered PTSD scale, Structured Interview for PTSD). Assess risk factors for PTSD including: premorbid mood disorders, emotional reactivity, stress symptoms, ruminative thinking, extrinsic blame of the event, history of trauma, or low social support. Use multiple informants, e.g. family or teachers, when assessing children.

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4. **Individuals with prolonged or repeated traumatic events** may develop additional symptoms, sometimes called complex PTSD, including: difficulties regulating emotion and problems with identity development, interpersonal functioning, impulsivity and adaptation. Given this overlap of PTSD and personality symptoms, assess for personality disorders as a differential or co-morbid diagnosis. Conversely, when an individual has a personality disorder, a trauma assessment and screening for PTSD should be considered.

5. **When assessing PTSD in children and adolescents**, utilize the specific DSM 5 criteria for children who are 6 years and under, and remember the expression of symptoms may be developmentally influenced. Young children may report generalized fears, e.g. stranger or separation anxiety, avoidance of situations related to the trauma, or sleep problems. Elementary-aged children may exhibit posttraumatic reenactment through play, drawings or verbalizations. They may believe there were omens or warning signs prior to the traumatic event and can predict and avoid future trauma by paying attention to these signs. Adolescents may engage in traumatic reenactment by exhibiting impulsive and/or aggressive behaviors.

**Treatment Guidelines:**

1. **Assess regularly for**: danger to self or others, depressive symptoms, grief and loss issues, high-risk behaviors, domestic violence, dissociation, psychotic symptoms, somatization, and substance use/abuse. It is common for individuals with PTSD to self-medicate with alcohol or other drugs, which can serve as an avoidance strategy and impede progress.

2. **Provide psycho-education** related to the natural course of PTSD, along with treatment options. For clients that are continually exposed to trauma because of their work, e.g. military, police officers, fire fighters, medical personnel, educate about natural reactions to these events, warning signs for when to seek help, and coping skills. Teach family members how to support and normalize their family member’s experience.

3. **Psychotherapy** should begin only after the person has been removed from the crisis situation and is no longer exposed to trauma. Appropriate training and supervision are necessary when treating PTSD. Evaluate benefits and possible harm of reprocessing the trauma, recognizing this may not be advised for a particular client at a particular time. Educate about the potential for symptoms to increase initially, before alleviating. If the decided course of treatment is reprocessing the trauma, ensure the client has support mechanisms and coping skills in place to assist with potential side-effects. Allow the client to control the pace. In addition, address areas of functioning that can be affected by symptoms of PTSD, such as family and social systems, work, and/or school.

4. **Evidence-based therapies** for PTSD include cognitive-behavioral therapy, exposure therapy and exposure based therapies, such as eye movement desensitization and reprocessing (EMDR), and stress inoculation training. Children may benefit from interactive therapies such as play therapy or trauma-focused cognitive behavioral therapy (TF-CBT) (see resources for link to online course.) Group therapy or support groups may be helpful for clients to share their struggles and achievements, normalize their experience and manage their current symptoms.

5. **Referral to a prescriber for pharmacologic treatment** can be helpful in conjunction with therapy. Medication is not for everyone. Symptoms of PTSD vary, and medication can be helpful in targeting specific symptoms, such as anxiety, mood, or sleep disturbance.

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6. **Collaborate** with clients and family as partners in recovery. Trauma often affects relationships with family and friends; for clients with PTSD related to sexual trauma, sexual relationships can be particularly affected. Teach methods for communicating about triggers, symptoms, and needs, and symptom self-management, including the positive physiological effects of stress management skills and aerobic exercise on symptoms such as anxiety.

7. **Ethnic and cultural factors** should be honored during treatment. Work to understand the social and cultural dynamics of PTSD. Cultural context and the meaning of traumatic events may affect the development, repression or reduction of symptoms as well as dictating decisions about whether to take medication or engage in a particular type of therapy. Be cautious when treating individuals from unfamiliar cultures. Some cultures have different norms and traditions around death and grief, and individuals can be further traumatized by the actions of well-meaning outsiders, e.g. in some Native American traditions, you never speak of the dead; discussions about the deceased must occur indirectly or in the third person.

8. **Self-care** for therapists is particularly important when working with trauma. Any professional who works directly with traumatized clients, and is in a position to hear the recounting of traumatic experiences, is at risk of secondary traumatic stress. Secondary traumatic stress is the emotional duress that results when an individual hears about the firsthand trauma experiences of another. Its symptoms mimic those of post-traumatic stress disorder (PTSD) [taken from this link](http://example.com). Be aware of your personal reactions to hearing about traumatic events, and attend to signs of secondary trauma, compassion fatigue or vicarious trauma. Obtain consultation, supervision, or your own therapy or support when needed.
References and Resources for Clinicians

Websites, Articles and Guidelines


Treatment Manual for Adult Therapists


Treatment Manuals for Child/Adolescent Therapists

- Trauma Focused CBT for children free online course: [http://tfcbt.musc.edu/](http://tfcbt.musc.edu/)
